PHYSICIAN–PATIENT RELATIONSHIPS: PATIENTS AS FRIENDS AND PATIENTS WHO HARASS

Boundaries between physicians and their patients, in friendships and relationships, have always been important but have recently become a source of great concern for physicians, communities and licensing bodies, particularly in regard to patient–physician sexual involvement. The article "Managing erotic feelings in the physician–patient relationship" (*Can Med Assoc J* 1995; 153: 1241–1245), by Drs. Gail A. Golden and Michael Brennan, provides a practical discussion of situations in which patients express sexual feelings or physicians experience such feelings and suggests setting boundaries on professional and personal relationships before erotic feelings arise. Their suggested limits would reduce the possibility of inappropriate sexual relationships with patients.

We agree with the need to avoid inappropriate sexual contact with patients and the suggested limits proposed, with the exception of the recommendation to "avoid socializing with patients." The authors comment that these rules may not be appropriate for every situation. In cities and towns it may be possible for physicians to keep patients separate from personal friends. However, in rural areas, such a separation of relationships is practically impossible, unless physicians have very few personal friends or very few patients. Over time, rural physicians provide medical care for many families within their community, through their own practice or while covering for colleagues. They will thus have many patients who become personal friends and vice versa. The richness of these relationships is part of the joy and satisfaction of rural family practice.[1]

When a patient and a physician are close friends, both their personal and professional relationships can suffer. Setting explicit boundaries together can help physicians and their patients and friends avoid potential conflict and maintain these valuable relationships. This is particularly important when the physician practises in a small community where such concurrent relationships are unavoidable. There are three important questions that physicians should ask themselves when they agree to care for a personal friend or when a patient becomes a personal friend: Am I too close to my friend to probe his or her intimate history and body and to cope with bearing bad news if need be? Can I be objective enough to avoid giving too much, too little or inappropriate care? Will my friend comply with my medical care as well as he or she would with the care of a physician who is not a friend? If these questions are kept in mind, physicians can more clearly explore the relationship and boundary issues that result from a professional and personal relationship.[1,2]

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2. LaPuma J, Priest ER: Is there a doctor in the house? An analysis of the practice of physicians' treating their own families. *JAMA* 1992; 267: 810–812

The article on managing erotic feelings addresses a topical issue of concern in medical practice. It fails, however, to differentiate between flirtation and harassment, and it assumes that the experiences and reactions of male and female physicians are identical.

When a patient shows sexual interest in a physician, the authors' advice is to accept the patient's feelings, be comfortable with discussing them, try to understand them and give a nonjudgemental response that provides reassurance, builds trust and fosters the patient's self-esteem. There is a brief paragraph about the physician's right to protect himself or herself in extreme situations when safety is an issue.

In a previous study, it was clearly shown that sexual overtures by patients toward female physicians are not uncommon, are often perceived as frightening and threatening and may leave the physician somewhat immobilized.[1] This patient behaviour should be termed "harassment," rather than "eroticism" or "flirtation." Most legal definitions of sexual harassment recognize that the perception of the victim is central to the interpretation of the behaviour in question. Sexual behaviour by a male patient with a female physician may have a far different meaning and intent than sexual behaviour of a female patient with a male physician. Similarly, the words and actions that are threatening to a female physician may seem humorous to her male colleague. To suggest that the role of the female physician is to reassure the perpetrator and foster his self-esteem is to blame the victim and

look to her for a solution to the problem. It would be more useful for a female physician to understand that the harassment she is experiencing is likely unrelated to anything she has done, has its roots in broader social stereotypes about women and is not something she has to fix.

Flirtation is an overstepping of boundaries; however, when actions are threatening, they represent an abuse of power and are properly termed "sexual harassment." The use of the term "flirtation" to refer to the abuse of power involved in a sexual invitation from a physician to a patient is also questionable.

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Reference

1. Phillips SP, Schneider M: Sexual harassment of female doctors by patients. *N Engl J Med* 1993; 329: 1936–1939

[The authors respond:]

We are grateful to Dr. Rourke and associates for their excellent letter, which adds an important dimension to our article.

Dr. Phillips' letter, on the other hand, is somewhat confusing, and she appears to have misinterpreted our objective. Our focus was on the inevitability and normality of erotic feelings in the physician–patient relationship, on tactics to protect the safety of both patients and physicians, and on fostering the emotional growth of both. Phillips prefers to consider such issues within a legal and political framework that focuses on the female physician as the victim.

We agree with Phillips that the experiences of male and female physicians are different, and that further exploration of these differences would be valuable. However, we do not agree that female doctors feel more "victimized"; in fact, it is our experience that male doctors may be more fearful of sexual encounters with patients than female doctors are. We believe that the balance of power between physicians and patients is very complex, that the sex of the two people affects that balance, and that a simplistic analysis will not help physicians manage their relationships more effectively.

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Informal clinical consulting via the Internet

Although the Internet has existed for several years, until recently it has been used primarily by scientific and technical workers. Now that Internet access has become commonly available through service providers, some patients are using this technology to aid in their medical care. The following case recently came to my attention.

A middle-aged communications technologist had noted for several years that food was getting caught in what he believed to be a pouch in his esophagus. Although this was not usually a problem, filling of the pouch was leading more and more often to vomiting in socially embarrassing circumstances.

Because the man did not have a family physician, he sought information on his condition from friends, relatives and the *Merck Manual*. He suspected that the description of Zenker's diverticulum in the manual matched his condition. He then conducted a search of the Internet (using the Lycos search engine) and found a reference to Zenker's diverticulum in an article I posted to GasNET (a clinical Internet resource at **http://gasnet.med.yale.edu**).

As a result, the patient telephoned me seeking clinical advice. I provided informal advice, outlined what investigations could be done and provided the patient with the names of clinicians with experience in esophageal conditions.

This story illustrates some of the useful ways patients may sometimes acquire clinical information. As the Internet continues to increase in popularity, I expect that patients will "surf the net" for information about their condition.

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Visions of our Medicare future: status quo has become a dirty word in Canadian health care [correction]

This article by Charlotte Gray (*Can Med Assoc J* 1996; 154: 693–696) left the impression that the proposal by the Health Action Lobby (HEAL) for a health-related transfer would cause the federal government to abandon funding for social assistance and postsecondary education. In fact, HEAL's proposal acknowledged the need for the government to ensure that enough targeted cash is transferred to the provinces and territories to provide reasonably comparable levels of health care, social services and postsecondary education across the country. — Ed.

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